MEDICAL ASSISTANCE ELIGIBILITY OVERVIEW

Department of Social and Health Services
Medical Assistance Administration

Special Edition
April 2004

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A paper version of this publication is printed regularly each October. On line users: see list site for updated Information as it happens.

***NOTE**: These are guidelines only. The Department of Social and Health Services (DSHS) has responsibility for making eligibility decisions for medical benefits.*

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Washington State Department of Social & Health Services

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This information is also available on the MAA website http://fortress.wa.gov/dshs/maa/ and click on Eligibility for Medical Programs.

NOTE: These are guidelines only. The Department of Social & Health Services (DSHS) has responsibility for making eligibility decisions for medical benefits.

To obtain this publication in alternative format, please contact the Department of Social & Health Services ADA Coordinator.

INTRODUCTION & DEFINITIONS

This guide offers an overview of eligibility requirements for medical programs. It does not include all requirements or consider all situations that may arise. Please contact your local Community Services (CSO) or Home and Community Services (HCS) office for information about a specific situation.

Income levels based on Federal Poverty Level (FPL) and Cost of Living Adjustments changes yearly. This booklet is updated regularly online to reflect those changes.

MEDICAID: the state and federally funded aid program that covers the Categorically Needy (CN) and Medically Needy (MN) programs.

CATEGORICALLY NEEDY (CN): the federally matched Medicaid programs that provide the broadest scope of medical coverage. Persons may be eligible for CN only, or may also be eligible for cash benefits under the SSI (Supplemental Security Income) or TANF (Temporary Assistance for Needy Families) programs. CN includes full scope of coverage for pregnant women and children.

FEE-FOR-SERVICE: the term used when a client is able to get care from doctors and other medical providers who will accept the MAA medical coupon called a Medical Assistance Identification card.

HEALTHY OPTIONS: the name of the Washington State, Medical Assistance Administration's managed care program.

MANAGED CARE: a prepaid comprehensive system of medical and health care delivery provided through a designated health care plan which is contracted with MAA.

MEDICALLY NEEDY (MN): a federal and state funded Medicaid Program for aged, blind, or disabled persons, as well as pregnant women, children and refugees with income and/or resources above CN limits. It provides slightly less medical coverage than CN.

TANF: the Temporary Assistance for Needy Families program offering cash and other benefits to families in need.

WORKFIRST: Washington State's Welfare to Work program for federal TANF legislation replacing the former AFDC program.

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FAMILY MEDICAL

TANF (TEMPORARY ASSISTANCE FOR NEEDY FAMILIES) and FAMILY MEDICAL PROGRAM: This program provides aid to children and adult(s) who care for them. Families with dependent children under the age of 19, whose income and resources are below TANF limits may receive both TANF cash benefits and CN medical. TANF cash benefits are restricted to 60 months maximum in a lifetime, but there is no time limit for receiving medical. **A family may choose to only receive CN medical to save TANF eligibility months.**

INCOME LIMITS – FAMILIES WITH DEPENDENT CHILDREN

NUMBER OF PERSONS	CN INCOME LIMIT
1	$349
2	$440
3	$546
4	$642
5	$740
6	$841

In determining net income, we deduct 50% of the family's earnings, actual child care costs, and child support paid out by the family.

RESOURCES: For medical eligibility, a family may have $1,000 in resources at the time of application. Once a family is eligible, there is no resource test for families who receive only medical.

MEDICAL EXTENTION BENEFITS (MEB): Families are eligible for up to 12 months of extended CN medical benefits when earned income increases above program standards. These benefits are sometimes called Transitional Medical Assistance (TMA). A premium is charged to all non-pregnant adults during the second six months of MEB, if the family's countable income is over 100% of the FPL. American Indian/Alaska Natives are exempt from the payment of premiums.

Families are eligible for up to 4 months of extended CN medical benefits when their cash

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SPECIAL SITUATIONS: Clients who are **not** eligible for cash benefits **but are eligible** for medical coverage include:

- Persons who are not cooperating with WorkFirst activities;
- Teen parents who are not in an approved living situation or are not meeting school requirements;
- Persons who have reached the 60-month TANF cash benefit limit;
- Other behavioral restrictions.

STATE FAMILY ASSISTANCE (SFA): SFA is the state-funded cash program for legal immigrant families who do not meet the eligibility requirements for the federal programs due to citizenship or immigration status. **Families on SFA are encouraged to apply for Basic Health (BH). See back page for BH phone number and web site.**

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WOMEN'S HEALTH

The CN medical program for low-income pregnant women has no resource limits and the income limits are based on 185 percent of the Federal Poverty Level (FPL)* The pregnant woman can be eligible at any time during her pregnancy. Once eligible, the woman continues to be eligible throughout the pregnancy and postpartum period regardless of changes in income and household composition.

To determine the pregnant woman's family size, count the pregnant woman and add one for each verified unborn.

EXAMPLE: A woman who verifies she is pregnant with twins is considered to be a three-person family.

Effective April 1, 2004:

NUMBER OF PERSONS	INCOME LIMIT – 185% FPL
1	NA
2	$ 1,926
3	$ 2,416
4	$ 2,907
5	$3,397
6	$ 3,887
Add $ 491 for each additional household member	

*Pregnant women with income above 185 percent FPL may be eligible for the MN program.

POSTPARTUM EXTENSION: The postpartum extension provides full scope medical coverage for women who receive medical benefits at the time their pregnancy ends. These funds provide continued medical coverage for 60 days after the month in which pregnancy ends (e.g., pregnancy ends June 10, medical benefits continue through August 31). Women receive this extension regardless of how the pregnancy ends.

FAMILY PLANNING EXTENSION: The family planning extension provides an additional 10 months of medical coverage for **family planning services only**. The extension follows the 60-day postpartum coverage for women who received medical benefits for the pregnancy. Women receive this extension regardless of how the pregnancy ends.

CASH ASSISTANCE FOR PREGNANT WOMAN: TANF cash benefits are available to pregnant women. Eligible women receive full scope medical coverage under (CN) Categorically Needy.

NONCITIZEN PREGNANT WOMAN: A pregnant woman is eligible for the CN scope of care under the noncitizen pregnant woman's program if she is not eligible for Medicaid due to citizenship or immigration status. This includes undocumented women.

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BREAST AND CERVICAL CANCER Treatment Coverage: This program began July 2001 and provides medical coverage for women who have been diagnosed with breast or cervical cancer or a related pre-cancerous condition. To be eligible, a woman must be identified as needing treatment through the Department of Health's (DOH) Breast and Cervical Health Program (BCHP) or by Breast and Cervical Early Detection program funded by the Centers for Disease Control. Income and resource eligibility is established by the DOH screening program.

An uninsured woman is eligible if she:

- Is under age 65;
- Has been screened by the BCHP and the CDC-funded program; and
- Requires treatment for breast or cervical cancer; and
- Does not have other insurance.

For more information see the Department of Health Web site at http://www.doh.wa.gov/wbchp/default.htm.

TAKE CHARGE: A Family Planning program that began in July 2001. The program covers pre-pregnancy family planning services, helping participants take charge of their lives before an unintended pregnancy occurs.

Both women and men may be eligible if:

- Their family income is at or below 200 percent of FPL;
- They do not have health insurance coverage; or
- Their current health insurance coverage does not include comprehensive family planning benefits.

Effective April 1, 2004:

NUMBER OF PERSONS	INCOME LIMIT – 200% FPL
1	$ 1,552
2	$ 2,082
3	$ 2,612
4	$3,142
Add $ 530 for each additional household member	

TAKE CHARGE covers:

- Annual examination;
- Family planning education and risk reduction counseling;
- FDA-approved contraceptive methods including: birth control pills, IUDs and emergency contraception;

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Over the counter contraceptive products such as; condoms and contraceptive creams or foams and Back to

- Sterilization procedures.

Services are accessed through local clinics, doctor's offices and pharmacies who are participating in *TAKE CHARGE*. For a list of providers by area call the toll-free Family Planning Hot Line at 1-800-770-4334. Additional information can be found on the DSHS Web site at http://maa.dshs.wa.gov/familyplan.

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CHILDREN'S MEDICAL

The CN medical program for children has two categories.

NEWBORNS: Newborns are automatically eligible for CN coverage for 12 months if their mother received medical benefits at the time of the child's birth. There are no income or resource limits. These children are not subject to premiums.

CHILDREN UNDER AGE 19: This CN program has no resource limits and the income limits are based on 200 percent of the Federal Poverty Level (FPL). Living with a parent/guardian is not a requirement for eligibility in this program.

- These cases are subject to a six-month Eligibility Review.
- Failure to return a required review will result in termination.
- Changes in circumstances can affect children's eligibility.

Effective April 1, 2004

NUMBER OF PERSONS	INCOME LIMIT – 200% FPL
1	$ 1,552
2	$ 2,082
3	$ 2,612
4	$ 3,142
5	$ 3,672
6	$ 4,202
Add $ 530 for each additional household member	

In determining the net income, the family can deduct a $90 earned income disregard for each working parent, the actual child care costs, and child support paid out by the family.

The 2003 Legislature passed a law requiring premiums for certain children on Medical Assistance. These premiums begin July 1, 2004. The premiums are based on a child's age and family income. Some children will not have premiums. A family pays for no more than 3 children –even if there are more children in the family.

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Children required to pay premiums:

Age	Income Above
0 – 1	185% FPL*
1 – 19	150% FPL

*Note: This does not include children whose mother received Medicaid on the day of the child's birth.

Premium amounts per child are:

FPL	Premium Amount
Over 150% to 200%	$10
Over 200% to 250%	$15

Household maximum: 3 premiums

http://fortress.wa.gov/dshs/maa/ProgramChanges2003/Premiums.html

CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP):

CHIP is a federal/state program that covers children under age 19 in families whose income is too high for Medicaid, but below 250% FPL. To be eligible for CHIP a child:

1. Cannot be eligible for Medicaid;
2. Cannot be covered by other creditable insurance; and
3. Must pay monthly premiums to the department.

CHIP has the same scope of coverage as the Categorically Needy program (CN). The program identifier on the Medical Identification card is F07.

Effective April 1, 2004:

NUMBER OF PERSONS	INCOME LIMIT – 200%-250% FPL
1	$ 1,940
2	$ 2,603
3	$ 3,265
4	$ 3,928
5	$ 4,590
6	$ 5,253
Add $ 663 for each additional household member	

Children with income above 250% of FPL may be eligible for the MN program.

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REFUGEES AND ALIENS :

Under the 100 percent federally-funded Refugee Program, a person who has been granted asylum in the U.S. as a refugee or asylee may receive cash benefits for a maximum of eight months. These persons automatically receive Categorically Needy (CN) medical services. Immediately after entering the U.S., families and single refugees are eligible for this program. Refugees/asylees who have been in the United States for more than eight months are determined eligible for medical benefits the same as U.S. citizens.

Refugees/asylees who have income above cash grant limits may be eligible for the Medically Needy (MN) program for a maximum of eight months, as described above, when they spend down excess income.

ALIEN EMERGENCY MEDICAL (AEM): Is a federally funded program for non-citizen aliens with an emergent medical condition(s). A qualifying emergency medical condition is described in WAC 388-500-0005. An applicant must be categorically related to a Medicaid program (e.g., a parent with a dependent child, a disabled adult or a child under age 19), but are ineligible for Medicaid due to citizenship or alien status.

- The CSO may need to refer a case to Medical Assistance Administration (MAA), Division of Disability Determination Services to determine client's disability;
- The CSO may need to refer a case to an MAA Medical Consultant to decide if the client has an emergent medical condition.
- Persons eligible for AEM can receive medical benefits for the emergent condition only.
- Income and resource limits are the same as for the program to which they are related, i.e., CN or MN.

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AGED, BLIND, AND DISABLED

SSI – RELATED MEDICAL COVERAGE

Aged, blind, and persons with disabilities may be eligible for Categorically Needy (CN) medical if their income and resource standards are the same or lower than the standards for SSI. People with income and/or resources above the standards may be eligible for the Medically Needy (MN) program.

SSI-eligible clients. Persons who receive federal cash benefits under the Supplemental Security Income (SSI) program also receive CN medical coverage automatically. The federal Social Security Administration (SSA) administers the SSI program. The SSI income standard is the Federal Benefit Rate (FBR).

Effective January 1, 2004:

NUMBER OF PERSONS	ABD RESOURCE LIMIT	ABD INCOME LIMIT AREA 1	ABD INCOME LIMIT AREA 2
1	$2,000	$570.90	$564.00
2	$3,000	$846.00	$846.00

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HEALTHCARE FOR WORKERS WITH DISABILITIES

Healthcare for Workers with Disabilities (HWD) is a CN medical program that recognizes the employment potential of people with disabilities. Under *HWD,* people with disabilities (age 16 through 64) can earn more money and purchase healthcare coverage for an amount based on a sliding income scale.

HWD has no asset test and the net income limit is based on 220 percent of the Federal Poverty Level (FPL).

Effective April 1, 2004:

NUMBER OF PERSONS	INCOME LIMIT – 220% FPL
1	$ 1,707
2	$ 2,290

To be eligible, a person must meet federal disability requirements, be employed (including self-employment) full or part time and pay a monthly premium based on the following formula.

Cost of enrollment:
To receive *HWD* benefits, enrollees pay a monthly premium equal to:

- ✓ Fifty percent of any unearned income in excess of the medically needy income level (MNIL) - the current MNIL is $571; and
- ✓ Five percent of all unearned income; and
- ✓ Two and ½ percent of earned income after deducting $65

American Indian and Alaska Natives are exempt from paying premiums for HWD.

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LONG–TERM CARE (LTC)

LONG-TERM CARE (LTC): LTC services are federally matched programs that fit individual needs and situations. Home and Community-Based services enable some people to continue living in their homes with assistance to meet their physical, medical, and social needs. When these needs cannot be met at home, nursing facility care is available.

Income limits for LTC programs vary depending on the services needed, living situation, and marital status. Some income may be allocated to a spouse and any dependents in the home. The client living at home keeps some income for home maintenance and personal needs. If the client is living in a residential setting, such as an adult family home, adult residential care, or assisted living facility (ALF), the amount of income kept depends upon the particular services received. The client who is living in a nursing facility (NF), keeps a small personal needs allowance **(PNA)** for clothing and incidental expenses. All remaining income is paid toward the cost of care; this is called **"participation."**

Resource limits also vary depending on marital status and other factors. All resources of both spouses are considered together. Certain resources are "excluded," such as the home, household goods and personal effects, a car, and life insurance with a face value not more than $1,500. Most burial plots and prepaid, revocable burial plans not exceeding $1,500, or irrevocable burial plans are also excluded and not counted toward the resource limits.

A Community Spouse (CS) is allowed to keep resources according to the spousal impoverishment legislation. The **Institutional Spouse** (IS) is allowed to keep the same resources indicated in the table on the following page for Aged, Blind and Disabled.

A different income standard is used to determine eligibility for categorically needy (CN) or medically needy (MN) coverage for LTC services. The standard is 300 percent of the Federal Benefit Rate (FBR) and is called the **Special Income Level (SIL).** If gross income is at or below the SIL, CN eligibility for either NF or Home and Community-Based (HCB) services, such as Community Options Program Entry System (COPES) may be approved. If income is above the SIL, MN eligibility may be approved with a spenddown only for NF services. Different rules are used when determining eligibility and participation when both spouses receive LTC services. The local Home and Community Services worker can provide this information as needed.
Effective April 1, 2004:

INSTITUTIONAL STANDARDS	INCOME LIMIT
Medicaid SIL (1/1/04)	$1692
PNA NF/hospital	$41.62
PNA state veterans home	$ 160
PNA single veteran	$90
COPES maintenance w/o community spouse (4/04)	$ 776
COPES maintenance with community spouse	$571

COPES maintenance in ALF	$571
Housing maximum (04/04)	$ 776
Community Spouse Maintenance (01/04)	$2319
Community spouse income allocation (04/03)	$1,562
Community spouse excess shelter allowance (04/04)	$469
Family allocation (04/04)	$1,562
Utility standard Effective (10/03)	$313
Spousal resource maximum (10/03) With spousal share exception up to $92,760 (1/1/04)	$40,000
Daily private nursing home rate (Effective 10/03)	$172
Monthly Private nursing home rate (Effective 10/03)	$5204

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MEDICARE SAVINGS PROGRAMS

Under four different Medicare Savings Programs, DSHS may pay the Medicare premiums for certain aged, blind, and disabled clients. These programs have higher income and resource limits.

QUALIFIED MEDICARE BENEFICIARY (QMB): The client must be entitled to or enrolled in Medicare Part A. Income limits are based on 100 percent of the Federal Poverty Level (FPL). Under QMB, DSHS pays for Medicare Part A, Part B, deductibles, copayments, as well as Medicare managed care premiums.

SPECIFIED LOW-INCOME MEDICARE BENEFICIARY (SLMB): The client must be entitled to or enrolled in Medicare Part A. Income limits are over 100 percent of the Federal Poverty Level (FPL) but under 120 percent of the FPL. Under SLMB, DSHS pays the client's Medicare Part B premium **only**.

QUALIFIED INDIVIDUAL (QI-1): The client must be entitled or enrolled Medicare Part A and not be eligible for any other Medicaid coverage. Income limits are from 120 percent of the Federal Poverty Level (FPL) to 135 percent of the FPL. Under QI-1, DSHS pays the client's Medicare Part B premium **only**.

QUALIFIED DISABLED WORKING INDIVIDUAL (QDWI): The client must be entitled or enrolled in Medicare Part A as a **working** disabled person who has exhausted premium-free Part A and whose SSA disability benefits ended because the clients earnings exceeded SSA's gainful activity limits. Income limits are based on 200 percent of the Federal Poverty Level (FPL). DSHS pays the client's Medicare Part A premium **only**. Persons considering this program may also benefit from information about the Healthcare for Workers with Disabilities program.

Effective April 1, 2004:

Medicare Savings Program	Federal Poverty Level	One Person	Two Persons
QMB	100%	$ 776	$ 1,041
SLMB	120%	$ 931	$1,249
QI-1	135%	$1,048	$1,406
QDWI	200%	$1,552	$2,082
Resource Limit		$4,000	$6,000

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MEDICALLY NEEDY (MN)

MEDICALLY NEEDY: MN (Medically Needy) is a federal and state-funded Medicaidprogram for aged, blind, or disabled persons, pregnant women, children and refugees with income and/or resources above CN limits. It provides slightly less medical coverage than CN, and requires greater financial participation by the client.

Medically Needy (MN) clients with income above MN limits are required to spend down excess income before medical benefits can be authorized. The client spends down the excess by incurring medical bills equal to the spenddown amount. **The client is responsible for paying those medical bills.**

Effective January 1, 2004:

NUMBER OF PERSONS	MN RESOURCE LIMIT	MN INCOME LIMIT
1	$2,000	$ 571
2	$3,000	$ 592
3	$3,050	$ 667
4	$3,100	$ 742
5	$3,150	$ 858
6	$3,200	$ 975
7	$3,250	$1,125
8	$3.300	$1,242
9	$3,350	$1,358
10	$3,400	$1,483
+10	+$50/Person	Maximum $1,483

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SPENDDOWN

SPENDDOWN: Spenddown is like an insurance deductible. Spenddown is the process through which excess income for MN is assigned to the client's cost of medical care. The client must incur medical expenses equal to the excess income (spenddown) before medical benefits can be authorized.

The amount of the client's spenddown is computed using a base period, consisting of three or six consecutive calendar months. Depending on when spenddown is met, the client may get medical benefits for all or part of the base period.

SPENDDOWN EXAMPLE: Applicant is a single woman, age 67. She receives $601 Social Security benefits each month and has $1,000 in savings.

Resources: The client's $1,000 resources are below the aged resource limit of $2,000, so she is resource eligible.

Income: Her income is above MN income limits, but MN allows spenddown of excess income. She is eligible for MN when she meets spenddown.

SSA benefits	$601
General disregard*	-20
	581
Less MN income limit	-571
Excess income	$ 10

The client can choose between a three-month or a six-month base period, depending on the amount of spenddown and the amount of medical bills she expects. She will have to incur either $30 ($10 times 3 months) or $60 ($10 times 6 months) medical expenses before she is eligible for MN. She will be responsible for these expenses; MAA will pay for her covered medical expenses after she meets spenddown.

*General Disregard: We allow $20 of the client's income to be disregarded when determining income limits.

MEDICAL CARE SERVICES (MCS): MCS is the state-funded medical program that provides limited medical benefits to persons eligible for Alcohol and Drug Addiction and Treatment and Support Act program (ADATSA) and General Assistance-Unemployable (GA-U). Income and resource limits are the same as for CN medical programs. MCS does not cover out-of-state medical care.

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GENERAL ASSISTANCE

GENERAL ASSISTANCE–UNEMPLOYABLE (GA-U): GA-U is a state-funded program that provides cash and Medical Care Services for persons who are physically and/or mentally incapacitated and unemployable for more than 90 days. Medical care is limited.

GENERAL ASSISTANCE–EXPEDITED MEDICAID DISABILITY (GA-X): The GA-X program provides cash and medical benefits to persons who have a disability decision pending with SSA. Eligible persons receive full scope CN medical coverage.

GA-U IMMIGRANTS: Immigrants determined to meet eligibility requirements for GA-U are eligible for state-funded Medical Care Services.

GENERAL ASSISTANCE FOR ALCOHOL AND DRUG TREATMENT (GA-W): ADATSA is the state-funded program that provides shelter and/or medical benefits, treatment, and support for persons incapacitated from gainful employment due to drug or alcohol abuse. Eligible persons receive limited medical coverage. Only medical is available to persons waiting to get into treatment. Income and resource limits are the same as for family CN medical.

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PSYCHIATRIC INDIGENT INPATIENT PROGRAM (PII)

Mental Health Division (MHD) created the PII program to ensure eligible clients receive continued psychiatric inpatient hospital services. The program funds voluntary community psychiatric inpatient hospital care for indigent clients who qualify.

Important: The maximum length of certification for PII is three months in any 12-month period.

Income and resource limits for the PII program are the same as for MN. Clients with excess income and/or resources above the MN limits must spend down the excess before they are eligible for PII.

The PII program pays only for emergent inpatient psychiatric care in community hospitals within the state of Washington. Psychiatric indigent inpatient (PII) does not cover ancillary charges for physician, transportation, pharmacy or other costs associated with a voluntary inpatient psychiatric hospitalization. For more information, contact Debbie Kingery, (360) 902-0778 at Mental Health Division.

MAA Provider memo 03-16 can be seen at:
http://fortress.wa.gov/dshs/maa/Download/Memos/2003Memos/03-16maa.pdf.

Involuntary psychiatric hospitalizations (commitments) are authorized under the Involuntary Treatment Act (ITA), RCW 71.05 and RCW 71.34. Generally, there is no change in how ITA cases are handled. For those who are **not** eligible for medical assistance, hospitals continue to use existing procedures to bill ITA cases. That process is separate and apart from the Psychiatric Indigent Inpatient (PII) program.

EMERGENCY MEDICAL EXPENSE REQUIREMENT (EMER):
PII requires a yearly (a continuous 12-month period) EMER of $2,000 per family before they are eligible. The EMER is comparable to a deductible on an insurance policy. An applicant can meet this requirement with voluntary inpatient psychiatric hospitalization **only.**

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MEDICAL ID CARD

Persons who receive medical coverage get a Medical Assistance ID card each month. Here is a sample ID card.

Sample Medical ID Card

Please read the back of this card

Medical Identification Card

This Card Valid From: **5/1/00 {2}**

{1} 411 E. Main Street
Anywhere, WA 98735

{25} LANGUAGE: SPANISH

F06 **{4}** **To:** **5/31/00 {3}**

PATIENT IDENTIFICATION CODE (PIC)				MEDICAL COVERAGE INFORMATION							
Initials	Birthdate	Last Name	TB	Insurance	Medicare	HMO	Detox	Restriction	Hospice	DD Client	Other
JR	100790	PUBLI	A			PLAN					
{5}	**{6}**	**{7}**	**{8}**	**{9}**	**{10}**	**{11}**	**{12}**	**{13}**	**{14}**	**{15}**	**{16}**
HIC	54474514A										

{17}

{18} J. R. Public
123 Main Street
Anytown, WA 98000

{19} CNP

{20}

{21} 1-800-555-6666 Plan

{22} 023 003455667

{23} L0000999 * 111234B

{24}

SHOW TO MEDICAL PROVIDER AT TIME OF EACH SERVICE

SIGNATURE (Not Valid Unless Signed)

DSHS 13-030 aces (04/95)

The codes below are the medical coverage group found in field 4 on the coupon. These codes identify the type of medical assistance the patient is receiving. Identification of medical coverage group helps the provider determine if the patient may be a Healthy Options enrollee.

Medical Coverage Group Codes – Field 4	**Medical Coverage Group Definitions**
C01, C95, AND C99	Waivered and Community Based Programs such as CAP, COPES
D01, D02	Foster Care, Adoption Support, and Juvenile Rehabilitation Services
F01, F02, F03, F04, and F09	Family Medical
F05, F06, F95, and F99	Children's Medical
F07	CHIP
GO1 and G02	General Assistance
G03, G95, and G99 facility (ALF)	Medical Assistance for a resident of Alternate Living Facility (ALF)
I01	Institution for the Mentally Diseased (IMD)
K01,K03, K95, and K99	Long Term Care – Families
L01, L02, L04, L95, and L99	Long Term Care – Aged, Blind, Disabled
M99	Psychiatric Indigent Inpatient (PII)
P02, P04, and P99	Pregnancy related
P05	Family Planning Only
R01 R02, and R03	Refugee
S01, S02, S07, S95, and S99	Aged, Blind, or Disabled (SSI) and Breast & Cervical Cancer Treatmt.
S03, S04, S05, S06	Medicare Savings Programs
S08	Health Care for Workers with Disabilities
WO1, W02 and W03	ADATSA

KEY TO MEDICAL ID CARD

AREA DESCRIPTION

1 Address of CSO.
2 Date eligibility begins.
3 Date eligibility ends.
4 Medical coverage group described in the table on the previous page.

Patient Identification Code (PIC) Segments Are:

5 First and middle initials *(or a dash (-) if the middle initial is not known).*
6 Six-digit birth date, consisting of numerals only *(MMDDYY).*
7 First five letters of the last name *(and spaces if the name is fewer than five letters).*
8 Tie breaker *(an alpha or numeric character).*

Medical Coverage Information

9 **Insurance carrier code** - A four-character alphanumeric code *(insurance carrier code)* in this area indicates the private insurance plan information.
10 **Medicare** - *Xs* indicate the client has Medicare coverage.
11 **HMO** *(Health Maintenance Organization)* – Alpha code indicates enrollment in an MAA Healthy Options managed health care plan. ***(Managed health care plan is the same as health maintenance organization or HMO).*** This area may also contain the legend PCCM *(primary care case manager).* The following ACES medical coverage groups, if not otherwise exempt, are required to enroll in Healthy Options: F01, F02, F03, F04, F05, F06, F07, and P02.
12 **Detox** - *Xs* indicate eligibility for a 3-day alcohol or a 5-day drug detoxification program.
13 **Restrictions** - *Xs* indicate the client is assigned to one physician and one pharmacist. The words "client on review" in Field 20 will also indicate restricted clients.
14 **Hospice** - *Xs* indicate the client has elected hospice care.
15 **DD client** - *Xs* indicate this person is a client of the DSHS Division of Developmental Disabilities.
16 **Other** - This area is not in use.
17 **HIC** shown here indicates that the client is on Medicare.
18 **Name** and address of client, head of household or guardian.
19 **Medical program** and scope of care indicators.
20 **Other messages** *(e.g., client on review, delayed certification, emergency hospital only).*
21 **Telephone number and name** of PCCM or Healthy Options plan.
22 **Local field office** *(3 digits)* and ACES assistance unit # *(9 digits).*
23 **Internal control numbers** for DSHS use only.
24 **Client's signature** - May be used to verify identity of client.
25 **Client's** primary language.

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COVERED SERVICES – AS OF JANUARY 2004

MAA provides a wide range of medical services. Not all eligibility groups receive all services. Coverage Is broadest under the Categorically Needy (CN) program and most restricted under the Medically Indigent (MI) program.

The table below lists major services which are available to clients by program: CN (Categorically Needy), MCS (Medical Care Services for GAU and ADATSA), and MN (Medically Needy). Disclaimer: The department is in the process of revising this chart and the chart below may not reflect all changes. We did remove the MI (Medically Indigent) program column since it was eliminated June 30, 2003.

SERVICE	CN[1]	MCS	MN
Adult Day Health	Yes	Yes	No
Advanced RN Practitioner Services	Yes	Yes	Yes
Ambulance/Ground and Air	Yes	Yes	Yes
Anesthesia Services	Yes	Yes	Yes
Audiology	Yes	Yes	HK
Blood/Blood Administration	Yes	Yes	Yes
Case Management - Maternity	L	No	L
Chiropractic Care	HK	No	HK
Clinic Services	Yes	Yes	Yes
Community Mental Health Centers	Yes	L[4]	Yes
Dental Services	Yes	R	Yes
Dentures Only	Yes	Yes	Yes
Detox Alcohol (3 days)	Yes	Yes	Yes
Detox Drugs (5 days)	Yes	Yes	Yes
Drugs and supplies, prescription	Yes	Yes	Yes
Elective Surgery	Yes	Yes	Yes
Emergency Room Services	Yes[8]	Yes[8]	Yes[8]
Emergency Surgery	Yes	Yes	Yes
Eye Exams and Glasses	Yes	Yes	Yes
Family Planning Services[5]	Yes	Yes	Yes
Healthy Kids (EPSDT)	Yes	No	Yes
Hearing Aid	Yes	Yes	HK
Home Health Services	Yes	Yes	L
Hospice	Yes	No	Yes
Indian Health Clinics	Yes	No	Yes
Inpatient Hospital Care	Yes	Yes	Yes
Involuntary Commitment	Yes	Yes	Yes
Maternity Support Services	Yes	No	Yes
Medical Equipment	Yes	Yes	Yes
Neuromuscular Centers	Yes	No	Yes
Nursing Facility Services	Yes	Yes	Yes
Nutrition Therapy	HK	No	HK

SERVICE	CN[1]	MCS	MN
Optometry	Yes	Yes	Yes
Organ Transplants	Yes	Yes	Yes
Orthodontia	L	No	No
Out-of-State Care	Yes	No	Yes
Outpatient Hospital Care	Yes	Yes	Yes
Oxygen/Respiratory Therapy	Yes	Yes	Yes
Pain Management (Chronic)	Yes	Yes	Yes
Personal Care Services	Yes	No	HK
Physical/Occupational/Speech Therapy	Yes	Yes	HK L[6]
Physical Medicine and Rehab	Yes	Yes	Yes
Physician	Yes	Yes	Yes
Podiatry	Yes	Yes	Yes
Private Duty Nursing	L	L	L
Prosthetic Devices & Mobility Aids	Yes	Yes	Yes
Psychiatric Services	Yes	No	Yes
Psychological Evaluation	L	L	L
Rural Health Services & FQHC	Yes	Yes	Yes
School Medical Services[3]	Yes	No	Yes
Substance Abuse/Outpatient	Yes	No[7]	Yes
Total Enteral/Parenteral Nutrition	Yes	Yes	Yes
Transportation Other Than Ambulance	Yes	Yes	Yes
X-Ray and Lab Services	Yes	Yes	Yes

KEY: **Yes** Service is covered (may require prior approval or have other requirements).
No Service is not covered.

HK Coverage limited to Healthy Kids program only (health checkup and treatment program for children under 21)

L Limited coverage

R Restricted to emergency medical conditions

1. Includes all CN programs, and services available to undocumented alien pregnant women.

3. A program for Medicaid children in school Special Education Programs.

4. Clients must meet the priorities and definitions of the Community Mental Health Act. Limited grants to counties fund these services.

5. All clients covered under all medical care programs receive family planning services. Women eligible for medical care during pregnancy receive family planning services only up to 12 months after pregnancy ends.

6. When the client is receiving home health care services.

7. Paid for out of ADATSA funds.

8. A $3 copay will be charged to non-pregnant adults who use the emergency room for services that are not related to an emergency medical condition. AI/AN are exempt from paying a copayment.

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Customer Toll-Free Numbers

Medical Assistance Customer Service Center (Clients) 1-800-562-3022
7am-6pm, Monday-Friday
TTY/TDD users only 1-800-848-5429

Medical Eligibility Determination Services (MEDS) 1-800-204-6429
TTY/TDD users only 1-800-204-6430

Pharmacy Authorization and Rates 1-800-848-2842

Provider Enrollment 1-866-545-0544
8am-4:30pm, Monday–Friday, 10am-4:30pm Wednesday

Provider Inquiry 1-800-562-6188

Third Party Resource Hotline (for clients to update health insurance information) 1-800-562-6136

Basic Health Plan 1-800-826-2444

Useful Web Addresses

DSHS Rules - (Washington Administrative Code)	http://www.leg.wa.gov/wac/
Economic Services Administration (to locate your CSO, applying for assistance including medical on line, etc)	https://wws2.wa.gov/dshs/onlinecso/
Eligibility A-Z Manual	http://www1.dshs.wa.gov/ESA/EAZManual/default.htm
MAA Internet	http://fortress.wa.gov/dshs/maa/
MAA Intranet	http://imaa.dshs.wa.gov/default.aspx
MAA Billing Instructions	http://fortress.wa.gov/dshs/maa/RBRVS/rbrvs.htm
MAA Numbered Memos	http://fortress.wa.gov/dshs/maa/Download/Memos/Year2004.html
Washington State Law (RCWs)	http://www.leg.wa.gov/rcw/index.cfm?fuseaction=title&title=74
Basic Health Plan	http://www.wa.gov/hca/basichealth.htm

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